

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155694	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/22/2014
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NAME OF PROVIDER OR SUPPLIER BETZ NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 116 BETZ RD AUBURN, IN 46706
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F000000	<p>This visit was for the Investigation of Complaint IN00154757.</p> <p>Complaint IN00154757- Substantiated, deficiency is cited at F-323</p> <p>Survey Dates: August 21 & 22, 2014</p> <p>Facility number: 000306 Provider number: 155694 AIM number: 100273860</p> <p>Survey team: Angela Strass, RN</p> <p>Census bed type: SNF/NF: 96 Total: 96</p> <p>Census payor type: Medicare: 13 Medicaid: 54 Other: 29 Total: 96</p> <p>Sample: 3</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2-3.1.</p>	F000000	We are requesting face to face IDR because we disagree with the scope and severity of F323.	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F000323 SS=G	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview the facility failed to prevent a fall for 1 resident (A) in a sample of 3 resident records reviewed for falls. This resulted in resident (A) having pain, experiencing a decline in his ability to transfer and suffering a fracture.</p> <p>Finding includes:</p> <p>Review of the clinical record for resident (A) on 8/21/14 at 2:00 p.m. indicated he was admitted to the facility on 2/7/12 with Diagnoses including but not limited to Dementia, Hypertension, and Anxiety. Review of the significant change MDS (Minimum Data Set Assessment) dated 5/17/14 indicated the resident was alert but had confusion, required extensive assistance of 2 staff for transfers and limited assistance of 1 staff for</p>	F000323	<p>F323 Free of Accident Hazards/Supervision/Devices – We are requesting face to face IDR because we disagree with the scope and severity of F323. -What corrective actions will be taken for those residents found to have been affected by the deficient practice? --Resident(A) fall interventions and care plans were reviewed and updated per IDT and recommendations were to not leave resident unattended on toilet. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? -All residents have the potential to be affected by the alleged deficient practice. -DNS/designee completed a chart audit for all residents at risk for falls to ensure that appropriate fall interventions were in place. -DNS/designee will in service and educate all nursing staff regarding the importance of the fall management/prevention program</p>	09/09/2014	

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	<p>ambulation. The resident also was not steady , only able to stabilize with staff assistance when moving off of the toilet.</p> <p>Review of a fall incident report, dated 5/31/14 at 9:20 a.m. indicated resident (A) fell off of the toilet in the central hall shower room. Staff indicated they had placed the resident on the toilet and had left the shower room to obtain a brief for the resident and upon returning to the bathroom observed the resident lying on the floor on his right side with his pants on.</p> <p>Review of nursing notes indicated the following:</p> <p>5/31/14 at 9:20 a.m. "Unwitnessed fall in shower room. Was alerted by aide that resident was laying on the shower room floor. Found resident laying on floor on his back. Resident was laying about 3 to 4 feet away from shower chair that he was sitting in using the toilet. Apparently he had got up on his own and walked a few feet. No injuries noted anywhere on his body. When asking resident if he hurt anywhere he states all over but apparently has a habit of saying</p>		<p>on or before 9/9/2014. What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not occur?</p> <p>-DNS/designee will conduct rounds each shift to ensure all interventions are being followed per care plan. -DNS/designee will in service and educate all nursing staff regarding the importance of the fall management/prevention program on or before 9/9/2014. -How the corrective action will be monitored to ensure the deficient practice will not recur, ie, what QA program will be put into place?</p> <p>-A CQI Fall Management tool will be implemented per DNS/designee weekly x 4 weeks, then monthly x 6 months. -Data will be collected per DNS/designee and submitted to the CQI committee, if threshold of 95% is not met, an action plan will be developed. Date of compliance 9/9/2014</p>				

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	<p>this in general. "</p> <p>5/31/14 at 12:30 p.m.—"Resident's wife in dining room with resident stating resident is complaining of left leg pain. When asking resident where he is hurting he states it is his right leg, not left leg and was found laying on the right side."</p> <p>5/31/14 at 12:32 p.m.—"Dr. paged regarding right leg pain."</p> <p>5/31/14 at 12:35 p.m.—" Dr returned page and informed him of residents pain right leg & he gave order to have x-ray done of right hip and leg."</p> <p>On 8/22/14 at 8:45 a.m. review of the x-ray report dated 5/31/14 indicated the following:</p> <p>"HIP UNI 1 V-R - The visualized osseous structures demonstrate faint lucency and cortical irregularity in the subcapital region of the right hip. Primary consideration should be given to a nondisplaced subacute fracture in this region until otherwise ruled out. Follow-up AP and frog leg lateral views recommended.</p> <p>AP VIEW RIGHT HIP - The</p>			

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	<p>examination is limited by an uncooperative patient. The visualized osseous structures demonstrate faint and cortical irregularity in the subcapital region of the right hip. Primary consideration should be given to a nondisplaced subacute fracture in this region until otherwise ruled out. No dislocation is seen. Mild joint space narrowing is noted.</p> <p>FEMUR 2V-R. – The visualized osseous structures demonstrate faint lucency and cortical irregularity in the subcapital region of the right hip. Primary consideration should be given to a nondisplaced subacute fracture in this region until otherwise ruled out.</p> <p>IMPRESSION: Views of the right femur were obtained. The examination is limited by an uncooperative patient. The visualized osseous structures demonstrate faint lucency and cortical irregularity in the subcapital region of the right hip. Primary consideration should be given to a nondisplaced subacute fracture in this region until otherwise ruled out. No dislocations is seen.</p>			

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	<p>TIB/FIB 2V-RT - Limited right tibia-fibula no acute fracture. If clinically indicated follow-up.</p> <p>IMPRESSION: Views of the right tibia-fibula were obtained. The examination is limited by an uncooperative patient. The visualized osseous structures demonstrate no evidence of an acute fracture or dislocation."</p> <p>Interview with Nurse #1, on 8/22/14 at 10:00 a.m. indicated she was working when the x-ray results came into the facility. She indicated she called the physician on the phone and also faxed the results to his office. Further interview indicated the physician did not give the facility any new orders for the resident.</p> <p>Further review of nursing notes on 8/22/14 at 10:15 a.m. indicated a note dated 6/6/14 at 3:18 p.m. "Staff reported that resident has had a decline in ability to assist with transfers. Stated that when 2 staff stood resident with gait belt, resident became weak and was difficult to transfer. Staff at that time performed transfer with a SARA lift (mechanical standing lift used to assist a resident with</p>						

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	<p>standing and transfers) and resident stood with this, holding where appropriate and bearing weight to legs without difficulty. New order noted to begin SARA lift for transfers and referral made to therapy related to decline in transfer status POA (Power of Attorney) updated.</p> <p>On 8/22/14 at 10:30 a.m. review of the clinical record did not indicate any therapy notes or orders. Interview with the Director of Nursing on 8/22/14 at 11:20 a.m. indicated therapy did not receive the order from nursing for an evaluation related to the residents decline in transfer status dated 6/6/14.</p> <p>Review of nursing notes on 8/22/14 at 10:30 a.m. indicated that on 6/21/14 at 6:20 a.m. "... (x-ray company) called and repeat x-ray of right hip ordered. X-ray is scheduled for today, but could possibly be tomorrow if schedule is to full." There was no documentation in the nursing notes which indicated why an x-ray was being ordered for resident (A). There was no documentation resident A had any other falls between 5/31/14 and 6/21/14.</p>						

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	<p>Interview with the Director of Nursing on 8/22/14 at 1:50 p.m. indicated the resident's wife had approached the unit manager on 6/21/14 and felt the resident was in pain and wanted an x-ray done..</p> <p>Nursing notes dated 6/21/14 at 11:22 p.m. indicated "X-ray result received. On-call MD notified. X-ray results read to MD and previous x-ray results reviewed. Due to resident's dementia and behaviors, MD states it would be more beneficial to resident to stay at facility until actual x-ray films can be reviewed by Ortho MD. Order received to notify attending physician for Ortho referral on Monday, non-weight bearing status, no walking, may sit up in chair. Due to late hour, will notify wife of new orders in morning.</p> <p>On 8/22/14 at 1:30 p.m. review of the x-ray results for resident (A) dated 6/21/14 indicated the following:</p> <p>"There is a right subcapital femoral neck fracture with mild displacement. The joint shows no dislocation. The pubic rami are intact. The bony structures appear</p>			

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	<p>osteopenic. There is no significant callus since 5/31/14. No significant healing of prior right femoral neck fracture as above.</p> <p>The resident was sent to the hospital on 6/23/14 per request of the family. Review of a nursing note dated 6/23/14 at 11:16 p.m. indicated staff had called the hospital for an update on the resident. Information given was the resident was admitted to the surgical floor for a hip fracture.</p> <p>This Federal Tag is related to Complaint IN00154757</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p>				